2009-2010 Vaccine Administration Record

Information about the person to receive vaccine (please print): ***Required Fields**

Name: (Last, First, MI)*	**DOB: (MM/DD/YY)***	**Sex: (Circle)*** M F
Address:*		

City:*	**State:***	**Zip:***	**Phone:*** ( )

INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	**Member ID #:***	**Group ID #:**

If Patient is not the Subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	**Subscriber's DOB:**	**Sex: (Circle)*** M F
Subscriber's Address:* **(If different from address above)**		

City:*	**State:***	**Zip: ***	**Phone:*** ( )
Patient Relationship to Subscriber:* **(Circle)**	**Spouse**	**Child**	**Other**

OTHER INSURANCE INFORMATION: *Include the prefix and suffix with the insurance ID number, if applicable.*

Insurance Company:*	**Member ID #:***	**Group ID #:**

I give permission for my insurance company to be billed.

X_____ **Date:** _____

(Signature of patient, parent or legal guardian)

****

For Clinic/Office Use: **Contact Person:** _____ **Phone Number:** _____

Vaccine Name:* (Circle)	**Vaccine Manufacturer:**	**Vaccine Lot Number:**	**Date Vaccine Administered:***	**Vaccine Type:* (Circle)**	**Injection Site: * (Circle)**	**Injection Route:* (Circle)**
H1N1 **Seasonal Influenza**			**(MM/DD/YY)**	**Dose #1** **Dose #2**	**Right Arm** **Left Arm** **Right Leg** **Left Leg**	**Intramuscular** **Intranasal**

Clinic Site Name: Newton Health & Human Services Department **Site PIN# :** _____

Clinic Address: 1294 Centre St. Newton Centre, MA 02459 **Vaccine Administrator:** _____

Date Vaccine Information Statement (VIS) given: _____ **Date on VIS:** 10/02/2009

Signature of Vaccine Administrator: _____ **Date:** _____